



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services
Local Educational Agency (LEA)
Medi-Cal Provider Enrollment Information Sheet
2014-2015 Fiscal Year



EDMUND G. BROWN JR.
GOVERNOR

Date: _____

Official LEA Name: _____

Doing Business As: _____
(DBA) (If different from the Official LEA Name)

Check all that apply New LEA (Complete PPA) Charter School Billing Consortium (Complete Consortium Billing Page) Update LEA Name (Complete PPA)

LEA Address Update Address (Complete PPA)

LEA Administrative Office Address: _____
(Not a Post Office Box)

Payment/Mailing Address: _____
(Complete ONLY if different from the Administrative Office Address)

LEA Contact Information Update Contact

Primary Contact: _____ Title: _____

Phone Number: _____ Email: _____

Secondary Contact: _____ Email: _____

LEA Vendor/Billing Agent Information Update Vendor Information

Vendor/Billing Agent: _____ Phone: _____

Contact Person: _____ Email: _____

LEA Identification Codes

California School Directory (CDS) Code: _____

National Provider Identification (NPI) Number: _____

LEA Federal Employer Identification Number (EIN): _____

Data Universal Numbering System (DUNS) Number: _____

LEA Authorization

Signature of Authorized Representative: _____

Typed or Printed Name of Authorized Representative: _____

Typed or Printed Title of Authorized Representative: _____

DHCS USE ONLY

Effective Date: _____

Date Added: _____



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

Local Educational Agency (LEA)
Consortium Billing
2014-2015 Fiscal Year



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* Enter the LEA name, CDS Code, and District for each LEA billing under the NPI number provided. Print additional pages if needed.

** Do not include individual schools within the district.

The following LEAs are part of: _____ consortium and bill under
(Type LEA Name)

NPI #: _____
(Type NPI Number)

	LEA Name	CDS Code (enter all 14 digits)	District Name (if different than LEA Name)	Charter (Yes/No)
1				
2				
3				
4				
5				
6				
7				
8				
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11				
12				
13				
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16				
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21				



State of California—Health and Human Services Agency
Department of Health Care Services
 Local Educational Agency (LEA)
 CERTIFICATION OF STATE MATCHING FUNDS FOR LEA SERVICES
(LEA Program Annual Report: ATTACHMENT 1)



EDMUND G. BROWN JR.
GOVERNOR

National Provider Identification Number

In accordance with the California Code of Regulations (CCR § 51270), Local Educational Agencies (LEAs) are required to certify a specific amount available in non-federal matching fund to participate in the LEA Medi-Cal Billing Option Program. The Local Educational Agency (LEA):

 (LEA Name)

has budgeted \$ _____ for the fiscal year beginning **July 1, 2014 and ending June 30, 2015** to cover wages, benefits, and administrative costs, of employees who provide health services and activities covered by the LEA Medi-Cal Billing Option Program.

This also certifies that the funds budgeted for the fiscal year are non-federal, certified public LEA Medi-Cal Billing Option Program eligible funds to finance LEA Program activities. These funds will be matched through the LEA Program claiming process to receive an equal amount of federal Medicaid funds. Once the LEA named above has received reimbursement from Medicaid in the amount set forth above, billings from this LEA shall cease until such time as it is re-certified that additional matching funds are available.

The undersigned is authorized to enter into this agreement on behalf of named School District/LEA; therefore, the School District/LEA is bound to the terms and conditions contained herein (all signatures must be in blue ink).

Date: _____

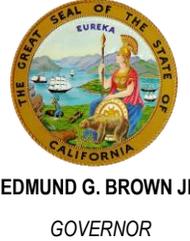
 Signature of Authorized Representative

 Name of the Authorized Representative

 Title of the Authorized Representative



State of California—Health and Human Services Agency
Department of Health Care Services
 ANNUAL REPORT FINANCIAL STATEMENT DATA
 FOR PRIOR YEAR CLAIMING
(LEA Program Annual Report: ATTACHMENT 1A)
July 1, 2013 – June 30, 2014
(LEA Medi-Cal Billing Option Revenue Only)



National Provider Identification Number

The Local Educational Agency (LEA):

 (LEA Name)

Total LEA dollars received during fiscal year 2013-2014 (a) _____
 (*amounts from DHCS 2013-2014 paid claims report)

Unspent LEA funds from previous fiscal year(s) (b) _____

Total Revenue (lines a + b) (c) _____

Reinvestment Expenditures made during 2013-2014, regardless of year the revenue was received:

Certificated Salaries	1000-1999	
Classified Salaries	2000-2999	
Employee Benefits	3000-3999	
Books and Supplies	4000-4999	
Services, Other Operating Expenses	5000-5999	
Capital Outlay	6000-6999	
Other Outgo	7100-7699	
Total Expenditures		(d) _____

Ending Balances as of June 30, 2014 (e) _____
 (Total Revenue [c] less Total Expenditures [d])

Anticipated service funding priorities of the LEA Medi-Cal Collaborative for use of unexpended revenue

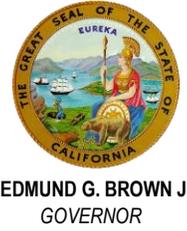
* Examples may be found in section 8804(g) of the Ed. Code and Article II (7) of the PPA.

List Program Service Items: (Ending Balance as of June 30, 2013 [e]).

* (do not attach additional sheets with ledgers or a breakdown of expenditures)



State of California—Health and Human Services Agency
Department of Health Care Services
 STATEMENT OF COMMITMENT TO REINVEST
 FOR CURRENT YEAR CLAIMING
(LEA Program Annual Report: ATTACHMENT 2)



National Provider Identification Number

The Local Educational Agency (LEA):

(LEA Name)

hereby certifies that:

- 1) A local collaborative has been formed;
- 2) The local collaborative will include among its responsibilities the decision making process regarding the reinvestment of funds made available through participation in the LEA Medi-Cal Billing Option Program; and
- 3) The reinvestment of funds will remain within the school-linked support services identified in provision seven (7) of the LEA Program Provider Participation Agreement.

As specified in the Local Educational Agency (LEA) Medi-Cal Billing Option Program Provider Participation Agreement (PPA), LEAs participating in the Medi-Cal Billing Option Program must submit an LEA Annual Report describing their collaborative, service priorities, and reinvestment expenditures each Fiscal Year (FY). Please describe the role of the collaborative by answering how reinvestment decisions are made, and the planned frequency of meetings.

1. Description of LEA Medi-Cal Collaborative decision-making process and frequency of meetings:

* The LEA collaborative is required to meet a minimum of twice a year.

a. How are LEA Medi-Cal Collaborative decisions made? (Check one)

Consensus Majority Vote Other

b. What is the frequency of LEA Medi-Cal Collaborative meetings? (Check one)

Monthly Every Other Month
 Quarterly Every Six Months
 Other - Explain: _____

2. Anticipated service funding priorities of the LEA Medi-Cal Collaborative for fiscal year 2014-2015

*(this describes plans for the potential use of Medi-Cal reimbursement that your LEA has not received yet):

List Program Service Items:



TOBY DOUGLAS
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State of California—Health and Human Services Agency
Department of Health Care Services
STATEMENT OF COMMITMENT TO REINVEST
(LEA Program Annual Report: ATTACHMENT 2A)



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National Provider Identification Number

The Local Educational Agency (LEA):

(LEA Name)

Signatures of the local collaborative partners below indicate an understanding of and commitment to the statement of commitment to reinvest outlined in Attachment 2 (all signatures must be in blue ink).

Note: The interagency collaborative shall consist of at least three individuals with varying interest in the reinvestment of funds for the LEA Program. The collaborative membership shall involve, representatives from the schools, public agencies serving children and families, parent groups of pupils of qualifying schools, community representatives, and private partners. Additional examples of collaborative partners can be found in section 8 of the PPA and section 8806 of the California Education Code. (Print additional pages if needed).

LEA INTERAGENCY COLLABORATIVE PARTNERS

Date: _____

Name of Collaborative Partner: _____

Organization of Collaborative Partner: _____

Signature of Collaborative Partner: _____

Date: _____

Name of Collaborative Partner: _____

Organization of Collaborative Partner: _____

Signature of Collaborative Partner: _____

Date: _____

Name of Collaborative Partner: _____

Organization of Collaborative Partner: _____

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